TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

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3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Title XIX (DMA)	
1. REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE 10-1-94

2. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

5. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT: a. FFY 1995 $ 27.9M b. FFY 1996 $ 27.9M
6. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19A	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: Same

8. SUBJECT OF AMENDMENT:

Acute Hospital Inpatient Payment System

GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:
Not Required under 45 CFR 204.1

11. SIGNATURE OF STATE AGENCY OFFICIAL: Bruce M Bullen 12. TYPED NAME: Bruce M. Bullen 13. TITLE: Commissioner, DMA 14. DATE SUBMITTED: 12-29-94	16. RETURN TO: Bridget Landers, SPA Coordinator Division of Medical Assistance 600 Washington Street, 3rd Floor Boston, MS 02111

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: December 30, 1994	18. DATE APPROVED: March 29, 2001
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 1994	20. SIGNATURE OF REGIONAL OFFICIAL: Joseph Mandalas for R Preston
21. TYPED NAME: Ronald P. Preston	22. TITLE: Associate Regional Administrator, DMSO/HCFA

23. REMARKS:

OFFICIAL

FORM HCFA-179 (07-92)

Instructions on Back

INSTITUTIONAL STATE PLAN AMENDMENT
ASSURANCE AND FINDING CERTIFICATION STATEMENT

STATE: Massachusetts **TN -** 94-20

REIMBURSEMENT TYPE:

Inpatient hospital	x
Nursing facility	
ICF/MR	

PROPOSED EFFECTIVE DATE: October 1, 1994

A. State Assurances and Findings. The State assures that it has made the following findings:

1. 447.253(b)(1)(i) - The State pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable state and Federal laws, regulations, and quality and safety standards. x

2. With respect to inpatient hospital services --

   a. 447.253(b)(1)(ii)(A) - The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs. x

   b. 447.253(b)(1)(ii)(B) - If a State elects in its State plan to cover inappropriate level of care services (that is, services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing services or intermediate care services, under conditions similar to those described in section 1861(v)(1)(G) of the Act, the methods and standards used to determine payment rates must specify that the payments for this type of care must be made at rates lower than those for inpatient hospital level of care services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act. x

   If the answer is "not applicable," please indicate:

c. 447.253(b)(1)(ii)(C) - The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality. x

3. With respect to nursing facility services --

a. 447.253(b)(1)(iii)(A) - Except for preadmission screening for individuals with mental illness and mental retardation under 42 CFR 483.20(f), the methods and standards used to determine payment rates take into account the costs of complying with the requirements of 42 CFR part 483 subpart B. ____

b. 447.253(b)(1)(iii)(B) - The methods and standards used to determine payment rates provide for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care under a waiver of the requirement in 42 CFR 483.30(c) to provide licensed nurses on a 24-hour basis. ____

c. 447.253(b)(1)(iii)(C) - The State has established procedures under which the data and methodology used to establish payment rates are made available to the public. _____

4. 447.253(b)(2) - The proposed payment rate will not exceed the upper payment limits as specified in 42 CFR 447.272:

a. 447.272(a) -Aggregate payments to each group of health care facilities (hospitals, nursing facilities, and ICFs/MR) will not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. x

b. 447.272(b) - Aggregate payments to each group of State-operated facilities (that is, hospitals, nursing facilities, and ICFs/MR) -- when considered separately -- will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles. x

If there are no State-operated facilities, please indicate "not applicable:" ___

c. 447.272(c) - Aggregate disproportionate share hospital (DSH) payments do not exceed the DSH payment limits at 42 CFR 447.296 through 447.299. x

B. State Assurances. The State makes the following additional assurances:

1. For hospitals --

a. 447.253(c) - In determining payment when there has been a sale or transfer of the assets of a hospital, the State's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate solely as a result of changes of ownership, more than payments would increase under Medicare under 42 CFR 413.130, 413.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital indebtedness, return on equity (if applicable, acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation. x

2. For nursing facilities and ICFs/MR--

a. 447.253(d)(1) - When there has been a sale or transfer of the assets of a NF or ICF/MR on or after July 18, 1984 but before October 1, 1985, the States's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate, solely as a result of a change in ownership, more than payments would increase under Medicare under 42 CFR 413.130, 413.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital indebtedness, return on equity (if applicable), acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation.

b. 447.253(d)(2) - When there has been a sale or transfer of the assets of a NF or ICF/MR on or after October 1, 1985, the State's methods and standards provide that the valuation of capital assets for purposes of determining payment rates will not increase (as measured from the date if acquisition by the seller to

the date of the change of ownership) solely as a result of a change of ownership, by more than the lesser of:

(i) 1/2 of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Dodge construction index applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year; or

(ii) 1/2 of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Consumer Price Index for All Urban Consumers (CPI-U) (United States city average) applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year. ____

3. 447.253(e) - The State provides for an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the State determines appropriate, of payment rates. X

4. 447.253(f) - The State requires the filing of uniform cost reports by each participating provider. X

5. 447.253(g) - The State provides for periodic audits of the financial and statistical records of participating providers. X

6. 447.253(h) - The State has complied with the public notice requirements of 42 CFR 447.205.

Notice published on: August 12, 1994
If no date is shown, please explain:

7. 447.253(i) - The State pays for inpatient hospital and long-term care services using rates determined in accordance with the methods and standards specified in the approved State plan. X

C. Related Information

1. 447.255(a) - NOTE: If this plan amendment affects more than one type of provider (e.g., hospital, NF, and ICF/MR; or DSH payments) provide the following rate information for each provider type, or the DSH payments. You may attach supplemental pages as necessary.

Provider Type: Inpatient Acute Hospital
Estimated average proposed payment rate as a result of this amendment: See Attached

Average payment rate in effect for the immediately preceding rate period: See attached

Amount of change: See attached Percent of change: See attached

2. 447.255(b) - Provide an estimate of the short-term and, to the extent feasible, long-term effect the change in the estimated average rate will have on:

(a) The availability of services on a statewide and geographic area basis:
No effect

(b) The type of care furnished:
No effect

(c) The extent of provider participation:
No effect

(d) For hospitals -- the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs:
no effect

I HEREBY CERTIFY that to the best of my knowledge and belief, the information provided is true, correct, and a complete statement prepared in accordance with applicable instructions.

Completed by Kim MacDonough Date 12/29/94

Title Senior Reimbursement Analyst Division Medical Assistance

OFFICIAL

Related Rate Attachment to Assurance and Finding Certification Statement

In accordance with 42 CFR 447.255, the Medicaid agency provides the following information on FY94 estimated average rates and the amount by which these have changed before and after the effective date of the State Plan Amendment.

Period	Estimate Acute Per Diem	Projected Annual Disproportionate Share Hospital Payments
7/2/94 – 9/30/94	868.00	336.0M
10/1/94 – 1/31/95	920.54	387.0M
Difference:	6.0%	15.2%

In accordance with 42 CFR 447.255, the Medicaid agency estimates that the change in estimated average rates will have no negative short-term or long-term effect on the availability of services (both on a statewide and geographic basis); the type of care furnished; the extent of provider participation; and the degree to which costs are covered in disproportionate share hospitals.

Methods Used to Determine Rates of Payment for
Acute Inpatient Hospital Services

I: OVERVIEW

On July 29, 1994, the Division of Medical Assistance of the Executive Office of Health and Human Services (hereafter referred to as "the Division") issued the Medicaid program's fourth Request for Applications (RFA) to solicit applications from eligible, in-state acute hospitals which seek to participate as Medicaid providers of acute hospital services. The goal of the RFA was to enter into contracts with all eligible, acute hospitals in Massachusetts which accept the method of reimbursement set forth below as payment in full for providing Medicaid recipients with the same level of clinical services as is currently provided by those hospitals and their hospital-licensed health centers. In-state acute hospitals which: (1) operate under a hospital license issued by the Massachusetts Department of Public Health (DPH); (2) participate in the Medicare program; (3) have more than fifty percent (50%) of their beds licensed as medical/surgical, pediatric or maternity beds, as determined by DPH; and (4) currently utilize more than fifty (50%) of their beds as either medical/surgical, pediatric or maternity beds, as determined by the Division, are eligible to apply for a contract pursuant to the RFA.

An Applicant's Conference was held on August 12, 1994, at which time interested parties could ask questions to clarify any aspect of the methodology. Written questions and comments were accepted through August 19, 1994. The RFA and its methodology became effective October 1, 1994. All eligible acute hospitals are participating providers.

II: DEFINITIONS

Administrative Day (AD) *- A day of inpatient hospitalization on which a recipient's care needs can be provided in a setting other than an acute inpatient hospital, and on which the recipient is clinically ready for discharge, but an appropriate institutional or non-institutional setting is not readily available. See 130 CMR 415.415 and 415.416 (attached as* ***Exhibit 1****).*

Administrative Day Per Diem *- An all-inclusive per diem payable to hospitals for administrative days.*

Clinical Laboratory Service *- Microbiological, serological, chemical, hematological, biophysical, radioimmunoassay, cytological, immunological, pathological, or other examinations of materials derived from the human body to provide information for the assessment of a medical condition or for the diagnosis, prevention, or treatment of any disease.*

Contract (Hospital Contract or Agreement) *- The agreement executed between each selected hospital and the Division, which incorporates all of the provisions of the Division's FY95 Acute Hospital Request for Applications (RFA).*

Contractor *- Each hospital that is selected by the Division after submitting a satisfactory application in response to the RFA and that enters into a contract with the Division to meet the purposes specified in the RFA.*

Department of Mental Health (DMH) Replacement Unit Services *- Services provided in beds located on a staff-secure and locked psychiatric unit operated by a hospital, which is designated by DMH to provide acute inpatient services for certain recipients. Such services are reimbursed under a separate hospital contract with DMH and the Division.*

Disabled Recipients *- Recipients of the Medicaid program who are eligible under SSI and Medicaid Disability Assistance (categories of assistance 03 and 07).*

Distinct Part Psychiatric Unit (DPU) *- An acute hospital's psychiatric unit that meets all requirements of 42 C.F.R. Part 412.*

Division *- The Commonwealth of Massachusetts, Executive Office of Health and Human Services' Division of Medical Assistance.*

Gross Patient Service Revenue *- The total dollar amount of a hospital's charges for services rendered in a fiscal year.*

Health Maintenance Organization (HMO) *- An entity approved by the Massachusetts Division of Insurance to operate under M.G.L. c.176G.*

Hospital *- Any hospital licensed under M.G.L. c.111, §51 and the teaching hospital of the University of Massachusetts Medical School, and which contains a majority of medical/surgical, pediatric, obstetric and/or maternity beds, as defined by the Department of Public Health, and for which such bed composition is indicated on the hospital's license, and which meets the eligibility criteria set forth in Section I of this State Plan amendment.*

Hospital-Specific Standard Payment Amount Per Discharge (SPAD) *- An all-inclusive payment for the first twenty cumulative acute days of an inpatient hospitalization, which is complete reimbursement for an acute episode of illness, excluding the additional payment of Outliers, Transfer per Diems, and Administratively Necessary Days.*

Inpatient Services *- Services reimbursable by the Division which are provided to recipients admitted as patients to an*

acute inpatient hospital.

Medicaid *- The Medical Assistance Program administered by the Division to furnish and pay for medical services pursuant to M.G.L. c. 118E and Title XIX of the Social Security Act.*

Medicaid MassHealth Managed Care *- A comprehensive managed care program which consists of a Primary Care Clinician (PCC) Program and a Mental Health/Substance Abuse (MH/SA) Program. (Patients served through this program are referred to as recipients assigned to managed care.)*

Merger *- A reorganization of two or more acute hospitals into a single fiscal entity.*

Outlier Day *- Each day during which a recipient remains hospitalized at acute (non-psychiatric) status beyond twenty acute days during the same, single admission. AD days occurring within the period of hospitalization are not counted toward the outlier threshold.*

Pass-Through Costs *- Organ acquisition and malpractice costs that are paid on a cost-reimbursement basis and are added to the hospital-specific standard payment amount.*

Pediatric Specialty Hospital *- An acute hospital which limits admissions primarily to children and which qualifies as exempt from the Medicare prospective payment system regulations.*

Pediatric Specialty Unit *- A pediatric unit in an acute hospital in which the ratio of licensed pediatric beds to licensed total hospital beds as of July 1, 1994 exceeds 0.20, unless located in a facility already designated as a specialty hospital.*

Public Service Hospital *- Any government-owned acute hospital which has a private sector payor mix that constitutes less than twenty five percent (25%) of its gross patient service revenue (GPSR) and where uncompensated care comprises more than twenty percent (20%) of its GPSR.*

Rate Year (RY) *- The period beginning October 1 and ending September 30.*

Recipient *- A person determined by the Division to be eligible for medical assistance under the Medicaid program.*

Sole Community Hospital *- Any acute hospital classified as a sole community hospital by the U.S. Health Care Financing Administration's Medicare regulations.*

Specialty Hospital *- Any acute hospital which limits admissions to children or to patients under active diagnosis and treatment of eyes, ears, nose, and throat, or diagnosis and treatment of cancer and which qualifies as exempt from the Medicare prospective payment system regulations.*

Transfer Patient *- Any patient who meets any of the following criteria: 1) transferred between acute hospitals; 2) transferred between a distinct part psychiatric unit and a medical/surgical unit in an acute hospital; 3) transferred between a bed in a DMH Replacement Unit in an acute hospital and another bed in an acute hospital; 4) receiving substance abuse-related services whose status in managed care changes; 5) who becomes eligible for Medicaid because other insurance benefits have been exhausted; or 6) whose status in managed care changes while receiving mental health-related services.*

Upper Limit *- The term referring to the level below which it is determined that the inpatient hospital reimbursement methodology will result in payments for inpatient hospital services in the aggregate that are no more than the amount that would be paid under TEFRA (Tax Equity and Fiscal Responsibility Act) principles of reimbursement.*

III: COVERED SERVICES

The Division will reimburse Medicaid participating hospitals in accordance with the methodology in Section IV of this State Plan for all acute inpatient services provided to Medicaid recipients except for the following:

A. ***Mental Health and Substance Abuse Services for Recipients Assigned to Managed Care***

The Division's managed care Mental Health/Substance Abuse (MH/SA) provider has implemented selective networks of providers to deliver inpatient mental health and substance abuse services for Medicaid recipients assigned to managed care. For Medicaid managed care patients receiving such services, network hospitals shall be paid pursuant to contracts between the hospital and the MH/SA provider.

Non-network hospitals do not qualify for Medicaid reimbursement for managed care-participating patients seeking non-emergency inpatient psychiatric and substance abuse services. If a managed care Medicaid patient is admitted on an emergency basis, non-network hospitals shall be paid by the MH/SA provider at the Medicaid transfer per diem rate capped at the per discharge amount for substance abuse-related admissions and at the Medicaid psychiatric per diem rate for psychiatric admissions.

B. ***Department of Mental Health (DMH) Replacement Unit Services***

DMH Replacement Units are specially designated to contain beds in hospitals that provide high intensity services to seriously mentally ill patients who previously would have received services at a public mental health hospital prior to the closing of state mental health facilities. The services provided in DMH Replacement Units are of a higher clinical intensity than the services traditionally paid for by Medicaid in general hospitals, and provide for the treatment of acute mental illness or an acute episode of long-term serious mental illness. They are staffed and operated by hospitals pursuant to three-way contracts with DMH and the Division. Payments for DMH replacement services will be made pursuant to the hospital's three-way contract with DMH and the Division.

C. ***HMO Services***

Hospitals providing services to Medicaid recipients enrolled in HMOs will be reimbursed by HMOs for those services.

D. ***Air Ambulance Services***

In order to receive reimbursement for air ambulance services, providers must have a separate contract with the Division for such services.

E. ***Hospital Services Reimbursed through Other Contracts or Regulations***

The Commonwealth may institute special program initiatives other than those listed above which provide, through contract and/or regulation, alternative reimbursement methodologies for hospital services or certain hospital services. In such cases, payment for such services is made pursuant to the contract and/or regulations governing the special program initiative, and not through the RFA and resulting contract.

F. Non-Acute Units within Acute Hospitals

Skilled nursing units within hospitals which have separate licenses will not be affected by this methodology. Chronic units within hospitals are covered by this methodology.

G. Out-of-State Hospitals

The Division will reimburse out-of-state hospitals in accordance with 130 CMR 415.404(B) (attached as ***Exhibit 2****).*

IV: REIMBURSEMENT SYSTEM

1. DATA SOURCES

In the development of the base costs per discharge, the Division used its FY90 Medicaid paid claims file; the FY90 RSC-403 report, as submitted by each hospital to the Rate Setting Commission (RSC); and the FY90 Merged Casemix/Billing Tapes as accepted by RSC, as the primary sources of data to develop base operating costs. These data were supplemented by information from each hospital's FY90 year-end Maximum Allowable Cost (MAC) report and information from the intermediaries for the Medicare program, as needed. If a hospital's FY90 RSC-403 was not available, the hospital's FY89 RSC-403 was utilized. The "per review" version of the FY90 MAC report was used, if available. If it was not available, the FY90 "as filed" version was used. (It should thus be noted that the Division used the same data in developing base costs per discharge for the RY95 RFA as was used in the RY94 RFA.)

The Division used the Medicaid paid claims file for dates of payment for the period June 1, 1993 through May 31, 1994 to develop the RY95 casemix index which adjusts operating costs. The Medicare cost reports (2552) for FY91, FY92 and FY93 and the FY91 MAC report were used to develop rates of payment for malpractice, organ acquisition, direct medical education and capital costs.

2. METHODOLOGY

A. Payment for Inpatient Services

1. Overview

Payments for inpatient services, other than for psychiatric services provided in distinct part psychiatric units, will consist of the sum of 1) a statewide standard payment amount per discharge that is adjusted for wage area differences and the hospital-specific Medicaid casemix; 2) a per discharge, hospital-specific payment amount for hospital-specific expenses for malpractice and organ acquisition costs; 3) a per discharge, hospital-specific payment amount for direct medical education costs which includes a primary care training incentive and a specialty care reduction; and 4) a per discharge, hospital-specific payment amount for capital costs which is a blend of actual FY92 costs and a reasonable capital cost limit. (Each of these components is described in detail below.) The statewide standard payment amount per discharge incorporates an efficiency standard.

Payment for psychiatric services provided in distinct part psychiatric units to Medicaid patients who are not served either through a contract between the Division and its MH/SA provider or in a DMH Replacement Unit shall be made through an all-inclusive regional weighted average per diem, updated for inflation and adjusted to reflect any reductions negotiated by the hospital and the Division's MH/SA provider (described in detail below).

2. ***The Standard Payment Amount Per Discharge (SPAD)***

The RY95 standard payment amount per discharge for a hospital is the product of the statewide standard payment amount per discharge, adjusted for inflation, casemix and wage area.

The statewide standard payment amount per discharge is based on the actual statewide costs of providing inpatient services to Medicaid recipients in FY90. The estimated actual costs of Medicaid patients in each hospital were determined using the Medicaid paid claims database for FY90, the FY90 RSC-403 and the FY90 MAC report. Cost and utilization data were excluded in calculation of the statewide standard payment amount per discharge for the following: hospitals with unique circumstances, as set forth in Sections IV.2.B.1-B.3; hospital units with unique circumstances, as set forth in Sections IV.2.B.2 and IV.2.B.4; and psychiatric units.

Estimated actual Medicaid costs were derived by a) multiplying Medicaid inpatient routine charges (net of AD routine charges) at each hospital by the hospital's cost-to-charge ratio for all routine services and b) adding this amount to the product of Medicaid inpatient ancillary charges (net of AD ancillary charges) at each hospital and the hospital's cost-to-charge ratio for all ancillary services.

Costs and charges associated with distinct part psychiatric units were excluded. Major moveable equipment depreciation and short term interest expenses were excluded as these expenses are treated as part of capital expenses. The cost center which is identified as the supervision component of physician compensation was included; professional services and other direct physician costs were excluded.

Salaried physician services provided directly to Medicaid patients receiving inpatient services will be paid on a percentage-of-charge basis.

Malpractice costs, organ acquisition costs and direct medical education costs were excluded from the calculation of the statewide standard payment amount as these are considered pass-through costs (as defined in Section II).

Capital costs were also excluded, as the reasonable level of payment for capital incorporates a separate efficiency standard.

AD days used in the inpatient calculation were obtained from the FY90 Medicaid claims data file. If the hospital's claims data had zero AD days or the AD days were less than three (3%) percent of its total hospital days, the FY90 RSC 404-A fourth quarter reported AD days were used for such hospitals.

The estimated Medicaid costs for each hospital were then divided by the number of FY90 Medicaid discharges at the hospital to derive the estimated actual Medicaid costs per discharge.

The estimated actual Medicaid costs per discharge for each hospital were then divided by the hospital's Medicare wage area index and by the hospital-specific FY90 Medicaid casemix index using the Version 8.0 New York Grouper and New York weights. (The wage area index reflects the reclassification of wage areas that have been approved by the Geographical Classification Review Board of the U.S. Health Care Financing Administration, effective July 31, 1991.) This step results in the calculation of standardized Medicaid costs per discharge for each hospital.

The hospitals were then ranked from lowest to highest with respect to their standardized Medicaid costs per discharge; a cumulative frequency of Medicaid discharges for the hospitals was produced; and an efficiency standard was established as the weighted median cost per discharge. The RY95 efficiency standard was established as the cost per discharge corresponding to the discharge located at the seventy-fifth percentile; this means that 75% of the Medicaid caseload was treated in hospitals whose operating costs were recognized in full. The efficiency standard of $2,551.55 at the weighted seventy-fifth percentile is the highest Medicaid cost per discharge that will be recognized for any individual hospital in the computation of the statewide standard payment amount.

The RY95 statewide standard payment amount per discharge was then determined by multiplying a) the weighted mean of the standardized cost per discharge, as limited by the efficiency standard; by b) the outlier adjustment factor of ninety-seven percent (97%); by c) an inflation factor of 3.35% which reflects price change between RY92 and RY93; by d) an inflation factor of 3.01% which reflects price change between RY93 and RY94; and by e) an inflation factor of 2.8% which reflects price change between RY94 and RY95. Each inflation factor is a blend of the HCFA market basket and the Massachusetts Consumer Price Index (CPI). Specifically, the CPI replaces the labor-related component of the HCFA market basket to reflect conditions in the Massachusetts economy. The resulting RY95 statewide standard payment amount per discharge is $2,346.78.

The statewide standard payment amount per discharge is then multiplied by the hospital's Medicaid casemix index (using version 8.1 of the New York Grouper and New York weights) and the hospital's Medicare wage area index (for the labor market area in which the hospital was classified by Medicare for 1993) to derive the hospital-specific standard payment amount per discharge (SPAD).

In RY94, the Division used both Medicaid paid claims and Rate Setting Commission Merged Casemix/Billing tapes for the casemix adjustment. In RY95, the Division used only Medicaid paid claims data for the casemix adjustment. The Division limited the impact of the change in the casemix adjustment experienced this year by any Contractor by limiting to 55% the impact that the facility would have otherwise experienced.

The outlier adjustment is used for the payment of outlier days as described in Section IV.2.A.8.

3. ***Calculation of the Pass-through Amount per Discharge***

The pass-through amount per discharge is the sum of the per discharge costs of malpractice and organ acquisition costs. In each case, the amount is calculated by dividing the hospital's inpatient portion of expenses by the number of total, non-psychiatric inpatient days and then multiplying the per diem costs by the hospital-specific Medicaid (non-psychiatric/substance abuse) average length of stay from Medicaid paid claims files for dates of payment for the period June 1, 1993 through May 31, 1994.

The inpatient portion of malpractice costs was derived from the FY91 MAC and updated by applying inflation factors of 3.01% and 2.80%. The inpatient portion of organ acquisition costs was derived from the FY93 Medicare Cost Report (2552).

4. ***Direct Medical Education***

The inpatient portion of direct medical education costs were derived from each hospital's FY93 Medicare cost report (2552). The amount was calculated by dividing the hospital's inpatient portion of expenses by the number of total (non-psychiatric) inpatient days and then multiplying the per diem costs by the hospital-specific Medicaid (non-psychiatric/substance abuse) average length of stay from casemix data. The Division has incorporated an incentive in favor of primary care training which was factored into the recognized direct medical education costs by weighing costs in favor of primary care training. An incentive of 33% was applied to the per discharge costs of primary care training; a discount of 20% was applied to the per discharge costs of specialty care training. The number of primary care and specialty care trainees was derived from data provided to the Division by the hospitals.

Growth in direct medical education costs attributable to wage inflation will be subjected to a 10% annual limit. An audit may be performed by the Division to verify the appropriateness of reported teaching costs.

5. ***Capital Payment Amount per Discharge***

The capital payment is a blend of actual capital costs, based on the FY92 Medicare cost report (2552), and a casemix-adjusted capital cost limit, based on the FY91 Medicare cost report (2552), updated for projected inflation, to be phased-in over five years.

For each hospital, the total inpatient capital costs include building and fixed equipment depreciation, major moveable equipment depreciation, and long-term and short-term interest. Total capital costs are allocated to inpatient services through the square footage-based allocation formula used in the Medicare cost report (2552). The Medicare cost report is also used to identify capital allocated to distinct part psychiatric units and to subtract this amount from total inpatient capital in order to calculate the (non-DPU) capital cost per discharge.

The capital cost per discharge is calculated by dividing total inpatient capital costs (less

that allocated to psychiatric DPU) by the hospital's total non-DPU days, and then multiplying by the hospital-specific (non-DPU) Medicaid average length of stay from casemix data.

The casemix-adjusted capital efficiency standard is determined by a) dividing each hospital's FY91 capital cost per discharge by its FY91 casemix index; b) sorting these adjusted costs in ascending order; and c) producing a cumulative frequency of discharges. The casemix-adjusted capital efficiency standard is established at the cost per discharge corresponding to the median discharge.

The capital efficiency standard was updated for inflation between RY93 and RY94 by a factor of 3.01%; and for inflation between RY94 and RY95 by a factor of 2.80%. For RY95, the casemix-adjusted capital efficiency standard per discharge is $307.54.

The capital efficiency standard shall be phased-in over a five-year period. In this third year of the phase-in, a hospital with capital costs below the median will retain 60% of the difference between its costs and the statewide standard; the capital payment for such a hospital will be the sum of the hospital's actual adjusted capital cost per discharge and 60% of the difference between the casemix-adjusted capital efficiency standard and the hospital's actual adjusted capital cost per discharge which is then multiplied by the hospital's RY95 casemix index to establish its per discharge capital payment amount. A hospital with capital costs above the median will be limited to the standard plus 40% of the difference between its costs and the statewide standard; the capital payment for such a hospital will be the sum of the casemix-adjusted capital efficiency standard and 40% of the difference between the casemix-adjusted capital efficiency standard and the hospital's actual adjusted capital cost per discharge which is then multiplied by the hospital's RY95 casemix index to establish the per discharge capital payment amount.

6. ***Maternity and Newborn Rates***

Maternity cases in which delivery occurs will be paid on a SPAD basis with one SPAD paid for the mother and one SPAD paid for the newborn. Payment for all services (except physician services) provided in conjunction with such a maternity stay including, but not limited to, follow-up home visits provided as incentives for short delivery stays, are included in the SPAD amount. There will be no additional payments to the hospital or other entities (i.e. VNA's, home health agencies) for providing these services in collaboration with the hospital.

7. ***Payment for Psychiatric Services in Distinct Part Psychiatric Units and Department of Mental Health Replacement Units***

a. ***Payment for Psychiatric Services in Distinct Part Units***

Services provided to non-managed care Medicaid patients in distinct part psychiatric units shall be paid through an all-inclusive regional weighted average per diem. This payment mechanism does not apply to cases in which services are provided to Medicaid recipients in DMH Replacement Units; or to cases in which